Documentation

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What is Documentation?

- Process of making an entry on a client record
- Also known as charting, recording, documenting

Why Document?

- Communication
- Planning client care
- Auditing health agencies – JCAHCO
- Research
- Education
- Reimbursement
- Legal consideration
- Health care analysis

Different Methods in Health Care Documentations

- **Source-oriented record**
  - Each person/department writes notations in a separate section of the client's chart.
  - **Narrative charting**
  - Traditional part of source-oriented record
  - Written notes in chronological order that include routine care, normal findings, & client problems

Different Methods in Health Care Documentations, cont.

- **Problem-oriented medical record (POMR)**
  - 4 basic components:
    - Database
    - Problem list
    - Plan of care
    - Progress notes – **SOAP format** (Subjective, Objective, Assessment, Plan)
      - Over the years, SOAP became SOAPIE, SOAPIER

Different Methods in Health Care Documentations, cont.

- **PIE (Problems, Interventions, & Evaluation)**
  - Consists of a client care assessment flow sheet & progress notes.
  - Incorporates an ongoing care plan into the progress notes
- **Focus charting**
  - Client's concerns & strengths are the focus of care
  - Consists of date and time, focus, & progress notes [DAR (data, action, & response)]

Different Methods in Health Care Documentations, cont.

- **Charting by exception (CBE)**
  - Only abnormal, significant findings or exceptions to norms are recorded.
  - Issue of "not charted, not done."
    - Recommendation is to write "N/A" on the flow sheets where the items are not applicable rather than leaving them blank.

Different Methods in Health Care Documentations, cont.

- **Case management**
  - Model uses multidisciplinary approach to planning & documenting care using "critical pathways."
  - Incorporates flow sheets that identify the outcomes that certain groups of clients are expected to achieve on each day of care, with interventions necessary for each day.

Different Methods in Health Care Documentations, cont.

- **Critical pathways** AKA "critical paths", "clinical pathways", or "care paths"
  - - management plans that display goals for patients & provide the sequence & timing of actions necessary to achieve these goals with optimal efficiency.

Example of Critical Pathways

Multidisciplinary Staff Actions ↓ ↓	Time →→ Day 1 (Day of surgery)	Day 2 (POD1)
Consults	Anesthesia for early extubation protocol	
Tests	EKG and CXR on admission to ICU	CXR in the AM or after CT removal
Medications	Analgesia/sedation per MD orders	1. PO analgesic 2. Adequate pain control achieved
Monitoring	Telemetry	Telemetry
Treatments	ET suction and lavage every 4 hours	Heated nebulizer to keep oxygen saturation ≥94%
Diet	Ice chips after extubation	1. Clear liquids 2. Patient tolerates clear liquids well
Patient/Family Education	Explain ICU routine to patient and family	Provide "Moving Right Along After Heart Surgery" booklet
Discharge Planning		Contact case management nurse

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Different Methods in Health Care Documentations, cont.

- **Case management**
  - Works best with simple cases.
- Advantages
  - Promotes collaboration & teamwork
  - Helps to decrease length of hospital stay
  - Makes efficient use of time & resources

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Different Methods in Health Care Documentations, cont.

- **Computerized documentation**
  - Orchid: Cerner – LAC computer program
  - Computerized charting manages the huge volume of client's information.
  - Care planning & documentation become relatively easy.
  - Transmit information from one setting to another.
  - Pros & Cons, see Berman, p. 230

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Essential Data in Health Care Records

- All data that pertain to Protected Health Information (PHI) under the Security Rule of HIPAA (Health Insurance Portability and Accountability Act of 1996)
  - E.g. name, birth date, social security number, address, telephone number, diagnosis, other health related information, etc.

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HIPAA

- PHI is identifiable health information that is transmitted or maintained in any form, including verbal discussions, electronic communications with or about the patients, & written communications.
- For education purpose, students are allowed to access health records.
- Students are bound by strict ethical code and legal responsibility to hold all information in confidence.
  - - Not using the name or any statements in notation that would identify the patient.

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Guidelines in Documentation

- Document the date & time of each recording.
- Follow the policy on the frequency of documentation, & adjust the frequency according to client's condition.
- All entries must be objective to prevent interpretation errors.

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Guidelines in Documentation

- Use only the approved abbreviations, symbols, and terms specified by the institution.
  - Error-Prone Abbreviations List , see separate handout
- Correct spelling must be used for accurate recording.
- Each recording is signed by the nurse making it. The signature includes the name and title.
  - Ex. *MGonzales, RN*
- Charting must be accurate, appropriate, complete, and concise.
- Always think about legal liability in charting.

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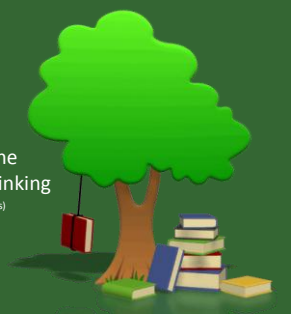
Accuracy of observation is the equivalent of accuracy of thinking
(by Wallace Stevens)

Fast is fine, but accuracy is everything. (by Wyatt Earp)



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